

South East **LHIN**

Better Integrated Health Services for Local Communities

2013/2014 Annual Report

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Ontario

Local Health Integration
Network

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LETTER FROM BOARD CHAIR AND CEO

On behalf of the South East LHIN Board of Directors and staff it is our pleasure to present the Annual Report for 2013/14.

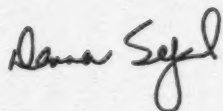
This Annual report highlights the South East LHIN's first year implementing its third Integrated Health Services Plan: Better integration, Better Health Care and demonstrates the South East LHIN's effort in striving to change the way care is delivered across the continuum and to enhance the patient experience through high quality integrated health care services.

One of the key component's in sustaining our healthcare system is to build capacity within the community sectors to enable patients with complex needs to live with greater independence close to home. Health Links has and will continue to be a cornerstone in helping us deliver on this. In the South East our seven Health Links have already demonstrated impressive results in how a coordinated care approach is leading to better health outcomes and overall experiences for patients and their families across the South East.

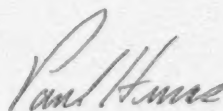
Building partnerships throughout our healthcare system is fundamental in helping us to identify opportunities for integration and streamlining of services in the South East. Projects such as Health Links, Addictions and Mental Health Redesign, Clinical Services Roadmap, and Hospice Integration are greatly informed by patients/clients, health service providers, and stakeholders while being supported by the appropriate governance structure. It is with the greater collaboration among these groups that enables us to move forward.

The South East is home to an incredible number of dedicated health care professionals that are committed to serving our local communities and we rely on their knowledge and expertise to enlighten solutions. We are proud to help all healthcare providers to look outside their organization's walls to see how together we can increase quality and to think as a system to find the most efficient way to deliver care to patients across our region.

We can only applaud the determination of the LHIN's staff that works with local health organizations' leaders and passionate health care providers to shape - one improvement at a time - a healthcare system that will better serve the people of the South East.



Donna Segal, Board Chair



Paul Huras, CEO,

Board of Directors

The LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions taken by the LHIN are directed by our Board. Our Chief Executive Officer (CEO) operationalizes strategic directions established by the Board and provides updates on our progress towards achieving our IHSP priorities through monthly reports on operational activities and key performance indicator results.

Donna Segal (Chair)

Appointed: 21 December 2012

Term Expires: 20 December 2015

Andreas von Cramon (Vice-Chair)

First Appointed: 28 April 2010

Term Expires: 27 April 2016

Arthur Ronald

First Appointed: 10 August 2010

Term Expires: 9 August 2014

Lois Burrows

First Appointed: 21 November 2012

Term Expires: 20 November 2015

Dave Sansom

First Appointed: 4 May 2011

Term Expires: 7 May 2016

Janet Cosier

First Appointed: 1 February 2013

Term Expires: 31 January 2016

Vacant position x 3

The South East LHIN Strategic directions

The South East LHIN Board of Directors has set in place four corporate strategic directions to guide decisions.

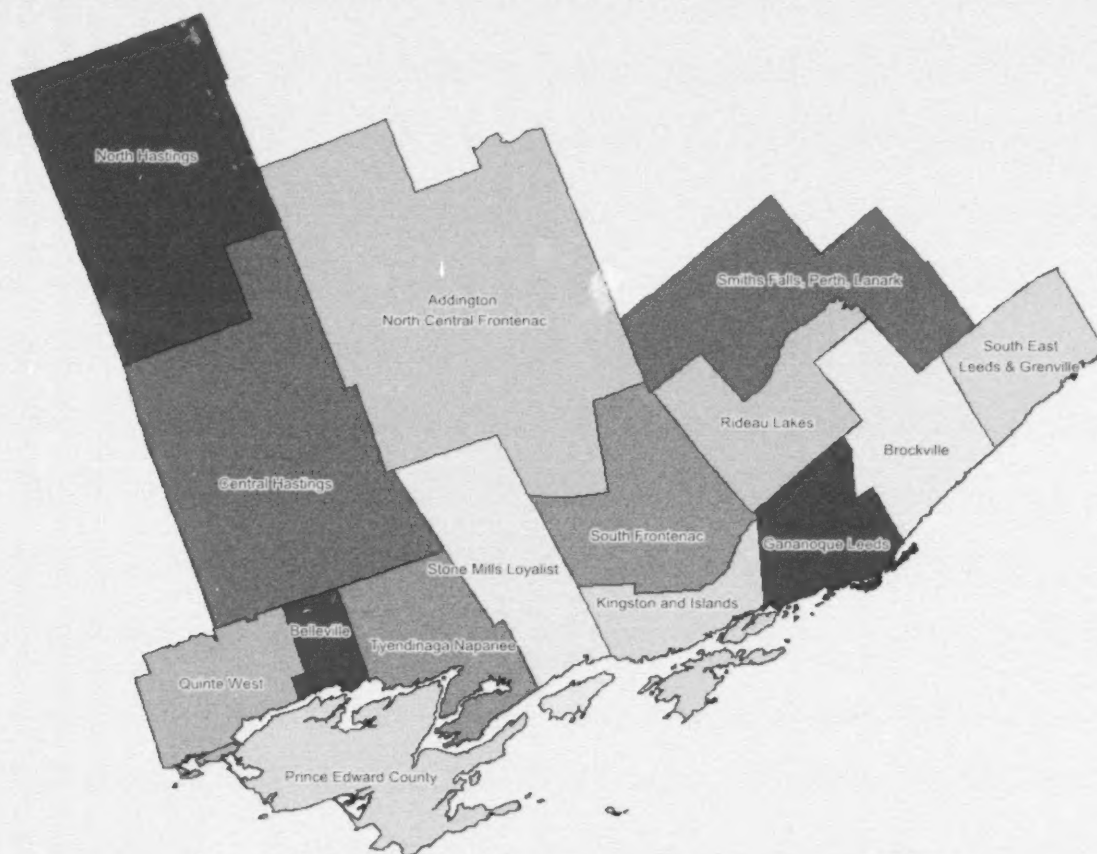
1. To build a true system of integrated health care that optimizes the use of resources
2. To build understanding of the role of the South East LHIN in developing and managing a regional system of integrated patient-centered care
3. To build a functional integrated e-health system that supports better health care services and healthier citizens
4. To demonstrate leadership as a knowledge-based organization that is credible, professional, proactive and responsive

THE SOUTH EAST LHIN COMMUNITY OVERVIEW

Geographically largest of the southern Ontario Local Health Integration Networks (LHIN), the South East LHIN encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the separated

towns of Smiths Falls and Prescott, and parts of Lanark and Northumberland Counties. For planning purposes, the South East LHIN is divided into 15 sub-LHIN regions which are identified in the map below.

Figure 1 : South East LHIN sub-LHIN regions



The South East LHIN Population

Home to about 497,000 people in 2013 (3.7 per cent of the population of Ontario) residing in 45 municipalities, the South East LHIN has the highest percentage of the population across all LHINs for both the 45+ and 65+ age groups. This will continue to be true at least until 2016, when 20 per cent of

the population will be 65+ in all areas of the South East LHIN with the exception of the following three sub-LHIN regions: Kingston and the Islands, South Frontenac and Stone Mills/Loyalist.

Between 2011 and 2016, the South East LHIN population in the 65-74 and 75+ age groups will grow annually by 4.5 per cent and 2.1 per cent,

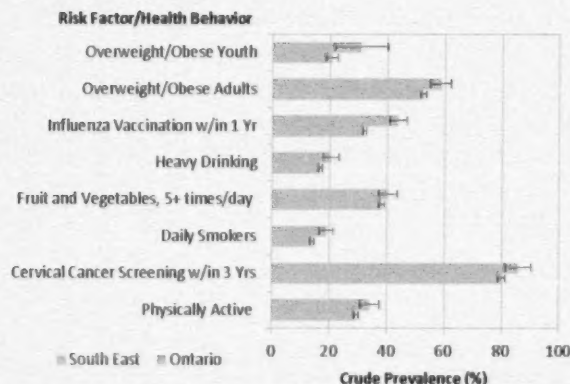
respectively. Annual growth for the 65-74 year age group will be greater than 4 per cent in all sub-LHIN regions except for Addington N/C Frontenac and Quinte West. In contrast, there will be slow to negative growth in children and young adults in all areas during this time period.

Overall, the annual growth rate in the South East LHIN between 2011 and 2016 is estimated to be 0.5 per cent. In the sub-LHIN regions of Kingston and Islands and Stone Mills/Loyalist, the annual growth rate is slightly higher but still sits at just over one per cent per year during this period. The South East LHIN is expected to pass the half million population mark sometime in 2015.

Population Health Profile

The South East LHIN has relatively high prevalence rates for a number of risk factors for illness and injury. Rates of overweight or obese adults and youth, current smokers, and heavy drinking are all higher than the provincial rates in calendar years 2011/12, as shown in Figure 2. However, the population in the South East LHIN also reports higher rates of positive health behaviors such as being physically active, cervical cancer screening, adequate consumption of fruits and vegetables, and influenza vaccination compared to the province as a whole.

Figure 2: Prevalence of various risk factors and positive health behaviors, South East LHIN and Ontario, 2011/12.

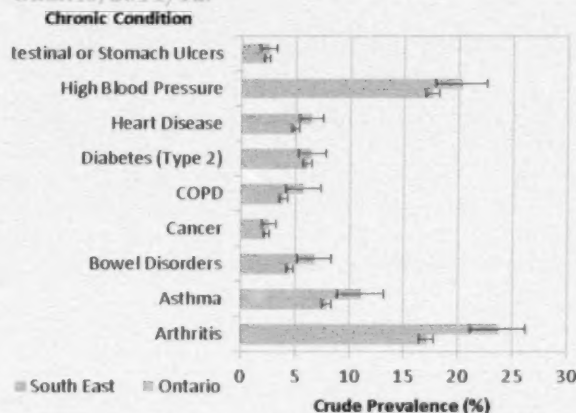


In terms of health status, a higher proportion of South East LHIN residents reported being limited in certain activities because of a physical condition,

mental condition, or health problem. Additionally, South East LHIN residents reported slightly higher rates of fair or poor self-perceived health, both generally and specifically for mental health. In terms of self-perceived stress, the South East LHIN had similar rates of high life stress compared to Ontario as a whole, and slightly higher rates of high work stress.

The South East LHIN also has high rates of certain

Figure 3: Prevalence of various risk factors and positive health behaviors, South East LHIN and Ontario, 2011/12.



chronic conditions compared to other areas of the province, as shown in Figure 3. This includes arthritis, asthma, bowel disorders, chronic obstructive pulmonary disease (COPD), high blood pressure, and heart disease. These higher rates persist even after accounting for the older population in the South East LHIN. The prevalence rates for cancer, diabetes, and intestinal or stomach ulcers were similar to provincial rates.

Healthcare investments

In 2013/14, the South East LHIN was assigned a budget of \$1,114,231,259 for the provision of health care services could meet the specific needs of the population through its Health Services Providers (HSP). Figure 4 (next page) shows the proportion of funds allocated to each health care sector in the South East LHIN.

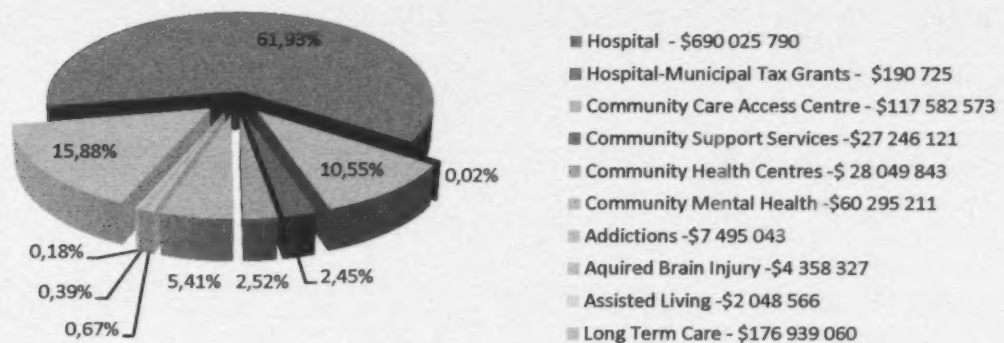
Health services providers delivering care in the South East region include:

- 7 Hospital Corporations - operating 12 sites providing a range of acute care, complex continuing care, rehabilitation, and mental health services
- 1 South East Community Care Access Centre (CCAC)
- 5 Community Health Centres - operating 8 locations (5 main sites and 3 satellites)
- 30 Long-Term Care providers operating 4,050 beds in 37 facilities
- 27 Community Support Services Agencies (CSS)
- 14 Organizations offering Addictions and Mental Health programs

The South East LHIN relies on 96 Service Accountability Agreements (SAAs) and related performance assessments, to appraise the performance of these agencies. By directing its attention on and addressing any performance issues, the South East LHIN is developing a regional healthcare system that not only provides high quality services but is sustainable for years to come.

The South East LHIN reports annually on its use of public funds and the success of meeting healthcare provincial goals and objectives.

Figure 4: 2013-2014 Percentage of Funding Allocation by Health Sectors



MINISTRY-LHIN INITIATIVES

As stated in Ontario's Action Plan for Health Care, the Ministry of Health and Long Term Care (MOHLTC) objectives and priorities are to provide Ontarians with:

1. Support to become healthier
2. Faster access and a stronger link to family health care
3. The right care, at the right time, in the right place

The South East LHIN shares these goals with the MOHLTC and is focused on a healthcare system that meets the needs of a changing population, as we work with our providers across the system to support them in the delivery of care with the patient as their absolute focus.

The South East LHIN's Integrated Health Service Plan (IHSP3) seeks to advance these objectives while outlining an approach tailored to address the South East specific priorities for the delivery of healthcare within the region. This approach supports three main objectives:

1. Developing a regional system of integrated healthcare across the care continuum, from primary care and public health through to community and acute and long-term care;
2. Improving the patient experience with a focus on the transition points in care; and
3. Focusing on the unique health care needs of Aboriginal and Francophone populations.

This document will report on the South East LHIN's initiatives which seek to advance broader provincial goals through the following:

- Health Links
- Addictions and Mental Health Redesign
- Increased investments to home and community services
- System Wide Patient Flow Strategy to reduce wait times
- Integrations Activities
- Enabling technologies

Health Links

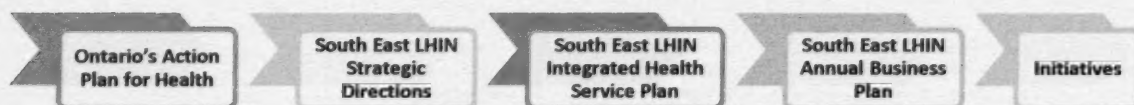
Health Links were introduced by the MOHLTC in 2013 to organize the delivery of Health Care differently by focusing on the needs of patients dealing with complex health conditions. To achieve better health outcomes, Health Links aim to develop greater collaboration and communication among all providers at the local level while integrating clinical care and coordinating care plans at the patient level.

With a growing elderly population, the South East LHIN adopted the Health Link model early on and was one of the first LHIN to announce the establishment of all seven Health Links that covered the entire geographic area of the LHIN.

Over the last year all South East Health Links in the South East submitted to the MOHLTC a business plan outlining the strategies developed to meet local needs for their respective complex patient populations. Five of these plans have already been approved with the other two expecting feedback early in 2014/2015.

Each Health Link has established a Steering

Figure 5: Alignment of the South East LHIN's Initiatives with Ontario's Action Plan for Health



Committee and broader stakeholder groups to identify priorities discuss strategies to meet local needs, and oversee the implementation of their business plans. This low-governance structure allows for innovative processes to inform the design of care delivery systems while ensuring decision making is respectful of the Health Link bottom-up approach.

Setting the Stage for Coordinated Care Planning

Coordinated care planning is a primary focus of Health Links. In the fall of 2013, Health Links in the South East LHIN began designing and testing ways to carry out effective coordinated care planning for complex patients. From the outset, Health Link Lead organizations, the South East Community Care Access Centre (CCAC), and the South East LHIN shared experiences and knowledge on coordinated care planning to identify and discuss regional improvement opportunities to benefit all Health Links.

To strengthen the continuous improvement approach and to build quality improvement capacity across the Health Links, the South East

Community Medicine, and the Central East LHIN to provide introductory-level quality improvement training to over 60 health care providers involved with Health Links.

Additionally, the South East LHIN successfully applied for and received approval for the development and initiation of two applied quality improvement projects as part of a ministry-led advanced learning program called Improving and Driving Excellence Across Sectors (IDEAS). The projects integrated directly into key Health Links initiatives as they focus on information transmission from acute care to primary care, and hospice palliative care.

In partnership with the University of Toronto, the South East LHIN offered a program entitled "*The Advanced System Leadership*" that focused on building more effective system leaders. For this unique leadership program 38 out of the 45 spots available, were assigned to participants engaged with Health Links representing a wide range of professionals from across all health care sectors.

Addictions and Mental Health Services Redesign

During public consultation undertaken for IHSP3, *Better Integration, Better Health Care*, the South East LHIN learned about the opinions and concerns of the residents in the region regarding the delivery of Addictions and Mental Health (AMH) services throughout this region.

It became incumbent on the South East LHIN to address the issues revealed through community engagement, in particular:

- Duplication of services;
- Multiple story telling or the repetitive assessments;
- Hurdles in transitioning between providers;
- Difficulty in accessing services;
- Insufficient volume of services to satisfy demand; and
- Stigma as a barrier to access services and other health services

7 HEALTH LINKS

- Thousand Islands HL
- Kingston HL
- Rural Kingston HL
- Quinte HL
- Rural Hastings HL
- Salmon River HL
- Rideau Tay HL

1 GOAL to build strong clinical networks to deliver high quality care to people with the most complex needs through coordinated care planning.

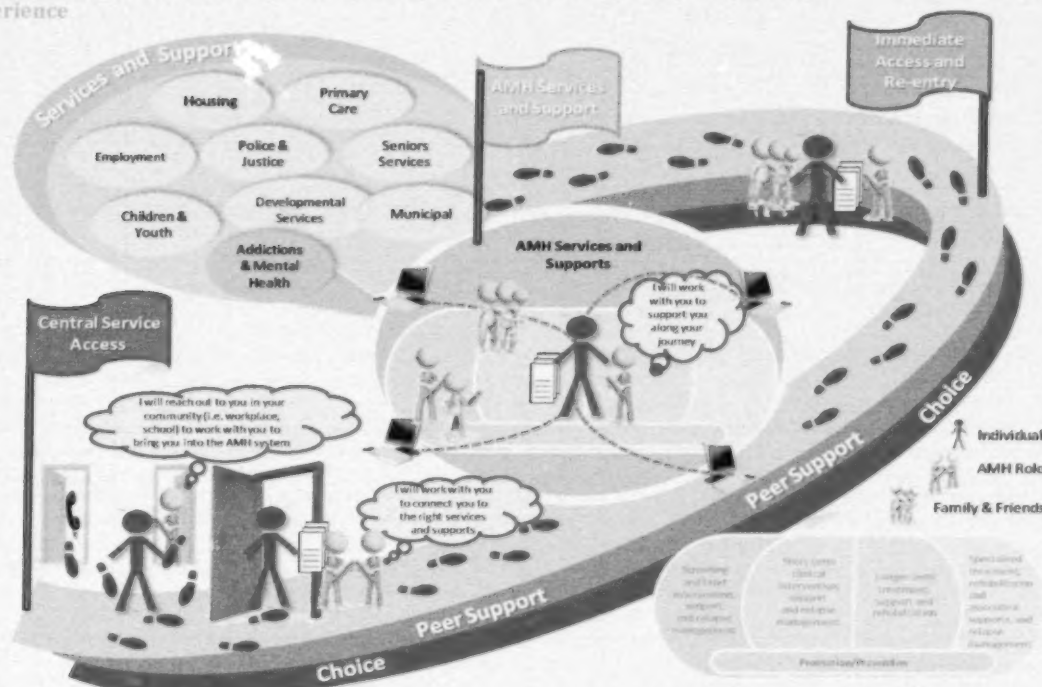
Over **150** coordinated care plans launched with patients and their teams of health care providers, as of March 2014.

LHIN partnered with Health Quality Ontario, the University of Toronto's Department of Family and

Clients would often end up in the Emergency Departments due to long waitlists, a lack of understanding as to where services can be offered, and a disconnect between care providers with respect to information sharing and care coordination.

The AMH Redesign was kicked-off by a "Visioning Day" to begin to develop the Ideal Individual Experience and Service Elements (figure 6). Building on previous public feedback, the Day brought together a broader range of participants all involved and interested in the delivery of AMH Health care in the South East region. Participants

Figure 6: South East LHIN Addictions and Mental Health Redesign – Ideal Individual Experience



With the intention of providing clients with the right care, in the right place, and at the right time, the South East LHIN initiated the process of redesigning AMH services in a way that will build upon our experience of excellent service delivery while achieving improvements in transitions in care and greater efficiencies. This will in turn improve access to high quality care for our residents.

Between January and March, 2013, the South East LHIN developed the AMH Redesign project plan. The project plan was then presented to and approved by the South East LHIN Board of Directors launching the AMH Redesign in April 2013.

included HSPs, clients, caregivers, hospital representatives, municipal housing, Ontario Department of Justice, Ontario Disability Support Program, Francophone communities' representatives, First Nations and Indigenous community representatives, children and youth services, police, justice, and other service providers.

To build the AMH Redesign from the ground-up, a Redesign Task Force (RTF) was developed from nominees who are also current providers of AMH Services in the South East LHIN region. Over a six month period, the RTF worked together, with feedback and recommendations from the broader stakeholders, to develop the Ideal Individual

Experience and the Service Elements needed to support this journey.

Over the past year, the redesign process has led stakeholders to validate the ideal patient journey, including all service components. To support AMH services in the South East, the Team moved forward with the planning process of the Future State for one of the governance options proposed.

Increased investments to Home and Community Services

In 2013/14 the Ontario Government provided additional funding to support home care and community services in the South East region. These investments are a key part of the province's Action Plan for Health Care, which is providing patients with the right care, at the right time, in the right place.

For the South East LHIN this additional funding represented an additional \$11.8 M to support home care for 3,000 more seniors and for expanded community health care services, including mental health supports, in the South East LHIN. Figure 7 illustrates how the increase was shared among providers to enhance the provision of community care and support services in the South East region.

This investment supported existing and new programs that work to reduce unnecessary emergency room visits and hospital readmissions, including:

- Home First, which ensures that seniors can be safely discharged from the hospital and cared

for in their own homes.

- A new Assisted Living Pilot Project, which provides supports that help seniors live independently at home while reducing wait times for long-term care.
- SMILE (Seniors Managing independent Living Easily), a program offering long-term functional support for frail and elderly seniors so they can remain in their home safer and longer as part of the Aging at Home philosophy
- Acquired Brain Injury (ABI) Residence in Napanee to accommodate people living with an ABI, by maximizing independence and quality of life

Increasing support services available at home and in the community

Over the last three years the South East CCAC has noted a 77 per cent growth in high needs patients. The increase in funding allowed the South East CCAC to enhance its capacity to support and care for a greater number of these patients and to continue to alleviate hospital pressures through the Home First philosophy, by reducing wait times for frail patients to access in-home personal support services. To address existing wait times between discharge and the initiation of support services, and to reduce the number of patients designated Alternate Level of Care (ALC) in an acute care setting waiting for Long-Term Care placement, the South East CCAC, guided by the Ontario Government, established a five-day maximum target standard for service initiation for high needs clients.

Figure 7: Allocation of the additional 11.8 M \$ in Community Care and Services



Additional funding allocation also allowed the South East CCAC to fully implement, and sustain Nurse Practitioners' (NP) initiatives in sectors such as mental health, palliative care as well as the Rapid Response Nurse initiatives. By targeting high needs clients, these programs enable patients to remain safely in their home while reducing the incidence of avoidable Emergency Room visits and hospitalizations.

Building on programs that work

Through the additional funding support the SMILE program has been able to create additional capacity for frail seniors to access SMILE support, specifically targeting those seniors that frequently visit the Emergency Department and/or appear to be failing in the community.

To appraise the program's impact the South East LHIN started to track avoidable hospital admissions and/or Emergency Department visits and comparing data with similar CCAC clients that do not receive SMILE support.

Delivering more responsive services in the most appropriate setting

Throughout the South East LHIN, there exists a significant gap in services for high risk seniors with complex needs who face physical limitations in carrying out essential activities of daily living, but who have the capacity to remain living in their own homes with the appropriate personal supports. The frequency and intensity of support services required by these seniors over a 24-hour period, however, moves them beyond the level of personal support service offered through a visitation model of care.

The South East LHIN initiated, at the end of the reporting period, the planning phase of an Assisted Living Services pilot project to fill this gap and better support high risk seniors who require services at a greater frequency or intensity than home care but without the medical monitoring or supervision that would be provided in a long-term care home. The planning phase of the initiative targets three geographic locations: Belleville, Kingston and Brockville

With the same goal of ensuring people are receiving the care they need in the most appropriate setting, the South East LHIN, along with local communities and partners, supported the construction of an ABI Supportive Housing Residence in Napanee.

The project, once completed will include two ABI residences each accommodating six people living with an ABI, by maximizing independence and quality of life. The construction of the first bungalow could begin early in Fiscal Year 14/15.

Residential Hospice as an alternative to Hospital for End-of-Life Care

An objective of the End-of-Life Care Strategy is to shift care of the dying from the acute care setting to appropriate alternate settings of individual choice. Although many individuals would prefer to receive end-of-life care at home, for some this is not possible. The residential hospice project aims to address this gap in the South East.

The primary focus of the residential hospice, launched in 2013 in Prince Edward County, is to alleviate pressures within acute care setting. Clinical services as well as nursing and personal support services are made available at the Hospice Prince Edward's three-bed residential hospice site through the South East CCAC contracted service providers.

System Wide Patient Flow Strategy

In the healthcare system, a hospital's Emergency Room (ER) remains the most impacted patient care area when patient flow bottlenecks occur in the system. If there is something not working right in the system, prolonged wait times in the ER result, preventing clients from receiving timely and appropriate care. When proper access to and flow through an emergency room is timely and successful, the public is confident that the healthcare system is functioning well.

The South East LHIN patient flow strategy was developed to align with Ontario's Action Plan for Health Care, to ensure patients received the care they need when and where it is most appropriate.

The South East LHIN continues to develop and refine an integrated, cohesive, and adaptable plan to address system-wide patient flow issues specifically focused on reducing the length of stays in hospitals, ER wait times and the time Alternate Level of Care (ALC) patients remain in hospital beds because they cannot return home or access a long-term care bed.

Established in consultation with area seniors and stakeholders, the LHIN strategy starts with

Pay for Results

The *Pay for Results* program's objective is to help South East LHIN hospitals fund projects aimed at decreasing overall ER wait times and lowering the time patients wait for an initial assessment. The three largest Emergency Departments in the South East received Pay for Results funding in 2013/14. As shown in Table 1, Kingston General Hospital (KGH), Quinte Healthcare Corporation (QHC-Belleville and Trenton Memorial site) have all noted improvements in patients accessing an ER or

Table 1: ER Wait Times reduction noted from Fiscal 2012- 13 to Fiscal 13-14.

Pay for Results Hospitals	ER LOS admitted	ER LOS non admit complex	ER LOS non admit non complex
KGH	Reduced by 12 mins	Reduced by 30 mins	Reduced by 78 mins
QHC - Belleville	Reduced by 18 mins	Reduced by 66 mins	Reduced by 84 mins
Trenton Memorial	Increased by 120 mins	Reduced by 12 mins	Reduced by 42mins

identifying clients at risk as well as "tipping points" in the health and well-being of seniors. The South East LHIN has outlined ways to assist this population to maintain independent living at home; and, reduce illness or injury which would require the use of ERs or admission to hospital.

To ensure patients have timely access to high quality care, the South East LHIN is focusing on four main areas of improvement:

- ER Wait Time Management
- Admissions and Inpatient Patient Flow
- Prevention/Care for ALC Patients
- Discharge & Transition of Care

ER Wait times - Performance & Capacity Management

Understanding the patient flow within an ER has helped the South East LHIN appreciate and improve upon ER wait times. The LHIN supports initiatives and programs striving to strengthen hospital performance and capacity management. Pay for results program and initiatives such as Short Stay units, Patient care navigators, Hospital at Home and Critical Care Life and Limb Policy contributed over the past year, to the reduction of the South East hospitals ER wait times.

internal hospital care as a result of the program.

Along with implementing several patient flow initiatives, South East hospitals' leadership teams had invested significant efforts into transforming the patient flow culture. Their efforts are starting to pay off as patients are now spending less time waiting in the ER.

Short Stay Units

The Inpatient Short Stay Unit is an around-the-clock model of care that addresses the need for defined patient population consistent with Quality Based Procedures that require less than or equal to 72 hour acute medical admission. This newly implemented initiative aims to:

- Promote and support transitions to primary care;
- Improve utilization of community supports and ensure sustainability of patients at home
- Initiate discharge planning and messaging at time of admission with predicted date of discharge, and
- Education and linkages for patients with multiple co-morbidities

The Kingston General Hospital's Short Stay Unit initiative continued to support patients requiring 72 hours of acute care while streamlining

admission and discharge processes to assist with organizational need. The lessons learned and model of care has been shared throughout the South East LHIN for the potential adoption by other organizations.

QHC adopted a similar short stay model, modified to their medical and surgical patient population, to help reduce the ER LOS for admitted patients. While Trenton Memorial Hospital dedicated Short Stay Units to pre and post-surgery care processes as well as acute inpatient services, QHC - Belleville Medicine Rapid Admission Unit beds now operates all week for periods of 16 hours every day to "pull" ER patients who are waiting for an inpatient bed.

Patient Care Navigators

Patient Care Navigators are clinical positions created to support safe and delay-free discharge for acute care internal medicine patients; personnel assist in repatriation of clients from other hospitals within the South East LHIN; and streamline internal and external processes to meet patients, families, and various health service providers' needs.

Patient Flow Navigators also focused on improving the following:

- Surveillance and improved utilization of the Clinical Decision Unit (CDU);
- Case finding for admit avoidance and cyclical hospitalization;
- Case finding for re-visits – supports and linkages to reduce ED utilization;
- Identifying the need for Occupational therapy and Physiotherapy assessments in support of discharge;
- Identifying appropriate patients for the Rapid Assessment Unit;
- Improving utilization of community supports and ensure sustainability of patients at home;
- Initiating discharge planning and messaging at time of admission with predicted date of discharge.

To meet increasing patient flow demands, QHC identified the need to increase access to discharge planning resources, provide case finding for off-

service patients, and ensure timely discharge planning and messaging at time of admission. Through process improvements QHC is now providing education, support and linkages for patients with multiple co-morbidities and promoting safe transitions to primary care.

While increasing the availability of Social Work/Patient Flow and Occupational Therapy at the Inpatient Unit/Emergency Department, QHC is also focusing on flow in and out of the short stay inpatient unit, case finding for admission avoidance and revisits, and is implementing restorative care plans to prevent functional decline leading to prolonged hospital stay.

Hospital at Home

Hospital at Home has been implemented by the Prince Edward Family Health Team, with the South East CCAC, QHC and the Centre for Studies in Primary Care of Queen's University. This is a physician led, inter-professional team based program that diverts appropriate patients requiring inpatient care to a program that provides daily visits and provides 24-hour access to physicians, nurse practitioners, registered nurses, personal support workers, social workers, physiotherapists, occupational therapists, and others. The partnership will maximize resources along the continuum and facilitate a smooth transition from the Hospital at Home to home care and/or other community services for patient across the region.

Critical Care Life and Limb Policy

Access to specialized care, especially to critical care, is essential for the optimal quality of care. As a result of the Clinical Services Roadmap (CSR) team's work, the South East LHIN hospitals have aligned with the provincial critical care policy to ensure all clients requiring critical care receive timely and appropriate care. It is expected that with this alignment improved utilization of Critical Care will occur.

Admissions & Inpatient Unit Flow

As discussed previously Short stay Units contribute to improve admission and inpatient flow. They also have an impact on predicted discharge date.

Predicted Discharge Date

Predicting a patient discharge date from both acute and post-acute care within 48 hours help the health care team to follow clinical pathways to ensure patients are receiving the right care, at the right time, and are discharged on the right day. This allows for advance planning of community resources needed to support the client at home but also allows for hospitals to plan for patient flow based on supply and demand. All South East hospitals as well as the South East CCAC have adopted this initiative to various degrees.

Prevention & Creation of Alternate Level of Care (ALC)

The South East LHIN is working with local providers to prevent patients from occupying a bed in a hospital when they do not require the intensity of resource/services provided in this care setting. Part of the solution is to ensure more capacity is created in alternate levels of care such as short stay units, as discussed previously, or to ensure patients are cared for in the community or at home when it is appropriate. Initiatives such as Senior-Friendly Hospital, Home First, and Nurse Led Outreach Teams have highly contributed to the prevention and creation of ALC in the South East.

Senior Friendly Hospital

The "Senior-Friendly Hospital" philosophy introduced in 2010 continues to be a major component of the South East LHIN's Clinical Services Roadmap (CSR) Restorative Care work plan. To date, all South East LHIN Hospitals have submitted their Senior Friendly Hospital plans identifying over 25 initiatives being implemented. Jointly these hospitals, the South East CCAC, and Behavioral Supports Ontario (BSO) are focused collaboratively on two key senior-friendly objectives: preventing functional decline and managing delirium, along with developing a LHIN-wide senior friendly hospital strategy.

Home First - acute/post-acute care

The Home First philosophy enables frail seniors to return home following an acute-care hospital stay, rather than being sent to a Long-Term Care Home (LTCH). It speaks to the cultural paradigm shift that sees many patients going home after their hospital care, whereas in the past they would have had to wait in hospital for a LTCH bed to become available.

Through an integrated discharge planning process, patients at high risk of being designated as ALC, are being identified earlier to avoid the physical and cognitive decline that can accompany a lengthy hospital stay. This process also helps avoid inappropriate ALC designation or delays in discharge.

In the early part of Fiscal 2013-14, post-acute care adopted the Home First philosophy to assist in the transfer of acute care patients to the post-acute care setting, such as rehabilitative or restorative care, prior to going home. This allows long stay post-acute care patients to go home as a final long-term destination.

Home First

"As of March 2014, out of the 934 assessed seniors,

463 seniors benefited from Home First to return home safely after an acute episode of care."

With the Home First approach, health care providers in the hospital work together with CCAC case coordinators and other community partners to explore available options to support patients returning home. Through a collaborative care approach, the post-acute care setting has ensured patients have access to the appropriate resources for the right period of time when they return home. To date there has been no readmission to post-acute care once the client has been given the opportunity to go home after their post-acute care is complete.

This initiative helps to reduce ALC in both the acute and post-acute care settings while reducing the demand for long-term care home beds, which, in turn, will enable those who do need that level of care to get it sooner.

Of those remaining in hospital, 25 per cent were ineligible for returning home because of challenging behaviours that would require intensive LTCH behavioral care. It is important to note that this patient population is one of the reasons the South East LHIN ALC days have increased significantly. The number of patients displaying challenging or responsive behaviours remains relatively stable; however, their hospital stays are longer. Additional analysis and work is needed to further reduce the number of patients remaining in hospital, along with a reduction in their associated length of stay.

Those remaining in hospital presented with barriers that prevented them from going home. For the majority of these patients, their care needs were too complex for home, they had no caregiver to care for them at home or they and/or their families were not comfortable about care being delivered at home.

Nurse Led LTC Outreach Teams

Most frail seniors in the South East LHIN live in LTCH. Their care needs are high, involve frequent assessments and monitoring, and can require treatments that LTCH staff are not familiar with or comfortable administering. Hence, many LTCH residents who fall ill are sent to the ER to receive care. This practice does not provide optimal care for the frail LTCH senior nor is it the best use of ambulance or hospital resources. Developed in 2009, Nurse Led Outreach Teams (NLOTs) expanded in 2012/13 and stabilized in 2013/14 to reduce unnecessary ER visits and optimize LTCH resident care.

Over 70 per cent of the South East LHIN LTCHs are now supported by a NLOT. The program is intended to build capacity among LTCH staff to improve system flow, prevent avoidable ER visits

and ensure that LTCH residents receive access to timely, high quality care within the comfort of their daily environment.

The NLOT model of care has not only reduced high and low acuity ER visits by LTCH residents – it has educated LTCHs about the role of nurse practitioners, and has established best practices for fall prevention, incontinence, hypoglycemia, early sign of pneumonia and other top reasons for ER visits.

Discharge & Transition of Care

CCAC Discharge Process - Coordinated Access to Care

Work done as part of the South East LHIN's Clinical Services Roadmap Emergency Department (ED) Wait time/Patient Flow work plans also concentrated on improving the communication and collaborative processes between hospital emergency departments, hospital discharge planners, and CCAC case coordinators, within the LHIN. Improving communication will facilitate timely discharge from acute and post-acute care settings. This role was also implemented during the Resource Matching and Referral (RM&R) initiative.

Integration Activities

A system that is too focused on providing acute hospital care and treating disease is inefficient and unsustainable. What is needed, instead, is a system that prevents serious illness and reduces the need for hospitalization and lessens the duration of long-term stay. Only an integrated health care system can do that, while remaining financially strong and effective. Clinical Service Roadmap, Resource Matching Referral and early detection are the main projects that intend to do just that within the local healthcare system.

Clinical Services Roadmap

As the catalyst to achieving a truly regionalized system of integrated health care the Regional Clinical Services Roadmap (CSR) has been a pillar of the South East LHIN's strategic activities throughout much of the past four years.

An Integrated Health Care System

"An integrated health care system eases the strain on hospitals by removing the burden of being the first point of contact in situations that could, and should, be handled in the community."

An integrated health system is able to:

- Do the kind of upstream work that helps people avoid the need for a trip to the hospital;
- give people the support, tools and knowledge to stay healthy at home;
- provide people with the care they need in their communities if and when they get sick or injured;
- Ensure that as patients navigate the transition points from provider to provider and service to service, they never fall through the cracks and they always receive the care they need, when they need it.
- Confirm that patients are treated in a timely fashion when hospital care really is required and that their discharge back into the community is coordinated and managed with their best interests in mind.

To improve patient flows across the care continuum over 15 initiatives related to the CSR were in various stages of implementation throughout the South East LHIN region in Fiscal 2013/2014 in all of the seven clinical areas of opportunity identified:

- Addictions & Mental Health Services
- Cardiovascular
- Emergency Department Wait Times
- Healthcare Acquired Infections
- Maternal and High Risk Newborns
- Restorative Care
- Surgery

Lead organizations have, to a large extent, embraced a patient-centered approach where services and programs are integrated amongst all health care providers and settings. Through active and ongoing engagement and building on strong relationships between LHIN, clinical, and administrative representatives from across the care continuum. The CSR teams maintained intensive collaborative interactions to share information, established data collection and reporting processes and in turn gained momentum on each project.

Surgery planning for the South East Clinical Services Roadmap

Taking into consideration the need for regional capacity planning, as well as the provision of regional urgent and emergent care, the region's hospital executives and the South East LHIN moved

forward with the development of a regional agreement for General Surgery and a draft for Urology. The proposed specialty agreement built on the foundation of the South East Regional Surgery Charter. Over the last year, the South East Ophthalmology team has contributed to the future state plan for: service provision; quality of care; access management; process standardization and efficiencies.

Resource Matching and Referral

Resource Matching and Referral (RM&R) is a standardized referral information pathway that facilitates referral of clients to the earliest available services that best meet their individual care needs. RM&R improves the patient experience, improve system wide patient flow and is designed to ensure all individuals have equitable access to appropriate care/services. RM&R improvements in the transitions of care for clients help reduce ALC days within the hospital setting.

In the South East LHIN the implementation of new RM&R information standards and referral pathways included the broader context of the CCAC Coordinated Access role from acute care to the range of post-acute and community settings of care to improve patient flow. Using leading practices, this partnership is helping to manage the transition of patients from acute care facilities back to their home safely or to post-acute care facilities, reducing or postponing the need for admission to a

LTCH. A Steering Committee was established to provide leadership to the change initiatives.

Significant initial progress has been made in all of the RM&R streams to date. The South East LHIN will continue with completing and automation of the RM&R system.

Early detection, timely care for High-Risk Seniors

The early identification of high risk frail-elderly patients by ER staff leads to an assessment of the community home support services they'll need if they are discharged from the ER. If they will be admitted, early identification leads to an inpatient assessment that will activate a care plan to prevent functional or cognitive decline.

Discharged hospital high-risk clients are put in touch with an *Integrated Community Assessment Referral Team* (iCART), who assesses clients from CCAC and Community Support Services. Care is coordinated through this integrated team, whose members share assessments and care plans to avoid duplication of services, client confusion and to ensure the client is visited appropriately to diminish anxiety, prevent social isolation, and avoid their seeking help through the ER for non-acute care needs. Over the last reporting period, two South East acute care hospitals implemented this initiative to improve overall integration of care and patient's experience.

Enabling Care Through Technology

The implementation of Enabling Technologies¹ initiatives is an important part of the South East LHIN mandate where technology projects aim to support quality improvement initiatives in the provision of health care services as well as facilitating collaboration across the care continuum and enabling information and data sharing among all regional stakeholders and practitioners.

Last year the South East LHIN invested time and resources in the development of the following enabling technologies:

- South East Health Integrated Information Portal (SHIIP)
- Regional Hospital Information System
- Regional Collaboration Space
- Clinical Document Repository (CDR)
- Ontario Lab Information System
- Eclipse Project Management System
- ED-CCAC

South East Health Integrated Information Portal

Person-centered care is a dominant expectation for what the healthcare system should deliver. An integrated, collaborative care model is necessary to enable this and it is evident that no single system of care has fully met the needs of individuals with complex health issues. A high performing primary care system can only be enabled with health information technology that effectively supports patients and providers, and allows for ongoing performance measurement as well as offers decision support capabilities.

The South East Health Integrated Information Portal (SHIIP) is a tool providing real-time feedback as well as summarized data to help track, plan and enhance the care of patients. Defined as a shared technology, SHIIP aims to assist in the identification of complex needs patients across the region, a key component in the care planning process.

To advance the SHIIP and support the Health Links coordinated care planning, the South East LHIN developed and initiated a four-phase regional plan. The overall purpose of the framework is to effectively integrate concepts of Information Management, Information Systems, and Information Technology (IT).

The development, submission and endorsement of the South East Regional Health Links Enabling Technology Framework represented the starting point of this project. Health Links Leads and the MOHLTC were both strongly supportive of the framework and the phased approach set forth therein, leading the South East LHIN to reach several key milestones between the submissions of the plan and the end of Fiscal 2013/2014:

¹Previously E-Health

- Development of SHIP mock-ups and validation by Health Links Leads;
- Approval of the Governance group's Terms of Reference;
- Formation of Health Links working group;
- Initiation of the SHIP development;
- Launch of the portal application testings;
- Instigation of discussions about privacy and data sharing agreements;
- Creation of the project charter.

ENABLING TECHNOLOGY

When focused on improving information sharing and supporting collaboration, technologies can really enable people and organizations to increase efficiencies and in return deliver better outcomes for patients and their family.

Once implemented SHIP will not only be able to identify groups of patients needing additional care, it will also:

- Facilitate performance monitoring and quality improvement efforts;
- Support collaborative, multi-agency care processes;
- Provide clinicians with a real time and historic view of patient information, electronically at the point of care;
- Identify gaps that typical Electronic Medical Records leave behind;
- Support both patient and provider needs for clinical management and care coordination; and
- Offer collaborative decision making possibilities.

Regional Hospital Information System

A Hospital Information System (HIS) is a comprehensive and integrated IT tool which is used to manage the medical, administrative, and financial aspects of hospital services. To drive efficiencies and savings in both capital and operational costs, local hospitals within the South East LHIN are cooperating on a new level to

converge their separate systems into a consolidated common one. Once complete, the new system will result in the use of common data standards across the region, as well as simplification of shared access to patient records across the participating sites.

The implementation of a common hospital information system across the South East LHIN will grant ER practitioners access to patient medical information regardless of where that patient is presented so better care can be delivered faster. Over the last year, hospitals have worked together to identify the existing gaps in information and embarked on an extensive needs assessment process to inform the development of a mutual HIS over the coming months. Through this process, shared support services for IT have been identified as a key component and an important source of savings for all hospitals across the LHIN.

Clinical Document Repository

The Clinical Document Repository (CDR) is a regional repository of the key patient records that are most commonly shared among health care providers across the continuum of care for those patients. This is a key component towards the development of an electronic health record for citizens of Eastern Ontario.

The CDR will have a significant impact on patients experience as it allows hospitals to access patient information regardless of where that patient is presented. As patients' information is made more broadly available and in a timely fashion, there is an expected decrease of paper flow between stakeholders leading to reduction in staff activities devoted to filing, retrieving, scanning, sending and management of reports.

Over the past year all seven hospitals in the South East region started using CDR to store and share information. Physician engagement sessions also started last fiscal with the first 90 physicians who signed the agreement to participate in the project. With a targeted number of 200 physicians to be signed and connected, the CDR should reach its full capacity of enabling communication of electronic

clinical documents between hospitals and primary care physicians through EMR, by the end of this coming year.

Emergency Department CCAC Notification System

The South East Emergency Department(ED) CCAC Notification System is a joint initiative of the South East CCAC, the South East LHIN, Kingston General Hospital, and Hotel Dieu Hospital. This project establishes a bidirectional gateway between ED and CCAC information systems. The ED CCAC system is designed to integrate CCAC and hospital patient and admission information to better inform both Clinicians and CCAC Case managers when patients visit the ER while receiving support service from the CCAC.

Not only ED CCAC offers a potential reduction in lost staff time for going to homes when client is in ER and increased efficiency in use of resources – representing cost savings for the entire healthcare system – but it also enhances awareness, collaboration and communication between CCAC and South East hospitals so more coordinated care is offered to discharged patients to prevent avoidable readmissions.

The implementation is now completed at both QHC and Lennox and Addington County General Hospital where the ED Notification System has been live since February 2014. In the next quarter an evaluation plan will be developed to report lessons learned and inform the expansion phase starting in 2014 at Perth and Smiths Falls District Hospital and Brockville General Hospital.

Ontario Lab Information System

Ontario Lab Information System (OLIS) is a provincial integrated repository of tests and results, aiming to improve patient care by granting practitioners with a timely access to laboratory results needed for clinical decision making. OLIS is a cornerstone information system that connects hospitals, community laboratories, public health laboratories, and practitioners to facilitate the secure electronic exchange of laboratory test orders and results.

All hospitals in the South East LHIN were involved in the planning phase of OLIS and Kingston and Brockville General Hospitals tested the proof of concept in February 2014. Pending eHealth Ontario approval and successful Transfer Payment Agency negotiations, the project should shortly transition to the implementation phase.

Eclipse Project Management System

Eclipse is a cloud-based tool assisting users to visualize the portfolio of healthcare projects, make decisions about priorities and understand resources utilization. The system supports project management by offering a collaborative platform and providing easy access to all interested parties so health care professionals can maintain and manage simultaneous projects from the planning to implementation phase with both internal and external partners.

While important projects at Kingston General Hospital, QHC and the South East LHIN benefit from the use of Eclipse, ongoing efforts are made to encourage the use of Eclipse for managing health care related projects in the South East. On-demand training sessions will also support Eclipse users across the region.

Regional Collaboration Space

To facilitate collaboration, increase communication and enhance information sharing amongst cross-organizational teams of healthcare workers as well as community practitioners across the region, the South East LHIN makes regional collaborative spaces available to them. These collaborative spaces are internal regional tools meant to improve efficiency and effectiveness, and support health care projects, as well as recurring activities that involve sharing information amongst health care providers and stakeholders.

This project started at the end of fiscal 2013/14 with a need assessment and is expected to quickly progress in support to several existing projects. Examples of applications include electronic reporting, referral, document sharing, clinician-to-clinician interactions, etc.

NEWLY REGIONALIZED PROGRAMS

Chronic Disease Management

The integration and coordination mandate for diabetes was transitioned to the LHIN on February 1, 2013 and the funding for both Adult and Pediatric Diabetes Education Programs (DEP) was transferred to the LHIN effective April 1 and December 1, 2013, respectively.

Following this devolution, service Accountability Agreements were established with the funded agencies for these programs and the South East LHIN soon supported the analysis of ER visits related to glucose management as a way to inform the development of the Diabetes Education Programs as well as to gain a clear understanding of all the factors underlying the high ER usage rate. Data were widely shared with the LHIN ER Lead and other service providers to start to uncover improvement possibilities for DEPs.

Based on long standing needs and a high amputation rate in the South East region, the LHIN funded the employment of three full time specialists to provide advanced foot care for patients with diabetes or vascular disease as well as one Diabetes Clinical Specialist Lead at the Kingston Hospitals to further advance the use of OTN in the prevention of and the education on diabetes.

The South East LHIN actively collaborates with other stakeholders on several provincial and regional committees and workgroups to plan, manage and improve the programs as well as the performance and integration of diabetes services within the care continuum. Bi-annual engagement sessions with service providers and clients covering the seven Health Links were organized to share information, identify issues and prioritize actions related to diabetes integration and coordination across the South East region.

Over the last 14 months, the integration of vascular health best practice into primary care, the transition of children to the adult diabetes system,

the psychosocial issues for children with diabetes as well as the performance reporting process review were identified by all stakeholders as key improvement areas within the South East region.

Physiotherapy

In 2013, the MOHLTC announced the expansion of physiotherapy services to ensure seniors, eligible community patients, and long-term care home residents are receiving the required services to help them stay healthy, physically active, and independent.

The South East LHIN has been working with health care partners and service providers to warrant and enhance access to services so more seniors could benefit from high-quality physiotherapy, exercise and falls prevention classes, while establishing an equitable distribution of these services across Ontario. As the program matures, there is a potential reduction of ER and ALC pressures.

Since August 2013, the physiotherapy initiative resulted in a significant expansion of services for seniors and patients of the South East such as:

- The identification of 14 new publicly-funded community physiotherapy clinics across the South East LHIN to deliver more than 6,100 episodes of care for seniors and eligible patients;
- The introduction of 135 exercise classes and 71 falls prevention programs to serve over 4,300 seniors in a community setting;
- The expansion of in-home physiotherapy to an additional 300 patients with mobility issues every month;
- The enhanced access to one-on-one physiotherapy for all long-term care residents with assessed need, in addition to group exercise and falls prevention classes; and
- The identification of potential sites interested in delivering physiotherapy services integrated into a family health care setting.

The South East LHIN is now engaged with Public Health Units to develop a comprehensive Falls Prevention plan for the region.

COMMUNITY ENGAGEMENT

Community engagement is more than a legislated responsibility; it is a core value of the South East LHIN. All community engagement activities aim at including the input of all stakeholders in the planning and decision making processes. By making sure the voice of the patients, community, health care providers, and leadership and governance members is heard and by working collaboratively, more creative and responsive solutions can arise leading to better integrated results for Ontarians in the South East and for the healthcare system.

Health Links

The creation and roll out of seven Health Links in the South East is a result of a broad range of community engagement actions over the past year to inform and collaborate with patients, communities, health care, and service providers as well as leadership.

Ongoing community information sessions are organized across the South East regions to increase public awareness on Health Links, their goals and early results. These information sessions were accompanied by videos and brochures explaining furthermore the Health Link concept and benefits for the patients and the providers.

Stakeholders including patients, caregivers, providers from all health care sectors, and different community groups participated in various workshops to lead the mapping of a patient journey within the actual system of care and the identification of improvements areas where Health Links can become a solution to existing gaps. These activities also allowed stakeholders to learn and share experiences as well as address specific care issues.

While information on Health Links spread, the collaboration between the emerging Health Links in the South East LHIN remained a key success to a fast adoption and implementation in the region. By working together and forging links between

them, each Health Link shared information, tools, issues, and best practices so they could learn from one another successes.

These networks extended to organizations leads and governance levels where engagement activities lead to the development of consistent and supportive action plans allowing Health Links to move forward and gain maturity. The South East LHIN has been working with Health Link Lead organizations to support planning and coordination and implementation of services at the regional level as well as establishing clear expectations and outcomes of performance to assess results in the future.

Addiction & Mental Health Redesign

The work of redesigning AMH services in the South East began in April 2013 with the official Launch of the Redesign occurring in June of 2013 at a 'Visioning Day' attended by more than 180 AMH service and community providers including; judicial, municipal, first response workers, and clients.

At the outset of the Redesign the South East LHIN also launched a Redesign Newsletter that was used as a key mechanism to regularly provide updates to stakeholders on progress to date.

Over the eight-month Redesign phase, multiple engagement sessions were held across the South East LHIN led by LHIN staff. Each engagement session helped to define the Ideal Client Journey, Service Elements, and Governance Structure Options. Providers and clients were able to discuss what would be fundamental to a new system of AMH care – using their own experiences and the experiences of others to frame their discussions

Two francophone engagement sessions were held with the Réseau and Francophone client representatives and helped to inform the redesign. Recommendations from those sessions will also inform the Future State Planning phase.

Through face-to-face focus groups, large working group events, webinars, online public surveys, email and through teleconferences public and stakeholders alike had the opportunity to provide input and feedback to the South East LHIN on the Ideal Individual Experience, the service elements, and the potential three governance options the Redesign Task Force (RTF) had developed to support them. A Validation Day was also held in December 2013, to engage the stakeholders in the review and validation of the above.

All along the redesign process the RTF kept the South East LHIN Board of Directors informed of the project evolution and sought governance insight on planning priorities and overall achievements.

At the end of the reporting period, the South East LHIN Board of Directors was presented with the three options that indicated how a future state of AMH services would look in the South East region. The Board moved forward with the recommendation and launched of the Future State Planning Process on March 31.

Prince Edward County Memorial Hospital Capital Project

Over the last period the South East LHIN held four face-to-face and teleconference discussions with key stakeholders towards the planning and re-launch of the Prince Edward County Memorial Hospital Capital Project. These meetings engaged stakeholders to reaffirm the commitment of all parties with a focus on expediting the same.

Expanding Culturally & Linguistically-Sensitive Health Care Services

The South East LHIN is committed to ensure there is appropriate access to care for both the French and the Indigenous communities of Southeastern Ontario. The LHIN engages both communities and health service providers working with them in discussions to plan, develop, and enhance the provision of healthcare services.

Indigenous Community

Ongoing engagement with Indigenous communities in the South East has been maintained over the 2013/14 fiscal year to further develop collaborative relationships with stakeholders in moving forward identified priorities. These engagements concentrated on the inclusion of the Indigenous communities' perspective within the AMH Redesign process as well as the implementation of an Indigenous Cultural Competency (ICC) training program.

Nearly one hundred South East LHIN HSPs were involved in three ICC educational sessions, led by the Indigenous Health Council, to strengthen cultural competency as well as to enhance their understanding of the Indigenous context. With similar goals in mind, the LHIN requested the Mohawks of the Bay of Quinte to lead a training session for LHIN staff and board members. At this point more than 70 per cent of South East LHIN staff and 50 per cent of board members have received this training.

Both training sessions promoted relationship building, which will in turn improve system capacity to better engage the Indigenous community in collaborative planning to address specific healthcare challenges. This will enable the South East LHIN and HSPs to advance healthcare priorities and improve health outcomes for this population.

Francophone Community

In accordance with the accountability agreement signed between the South East LHIN and the French Language Health Planning Entity (FLHPE), also called the Réseau, one of the roles of the LHIN is to seek advice from the Réseau on Community Engagement that relates to the Francophone communities in our region.

Falling under this accountability agreement, the South East LHIN and the Réseau also develop and implement a Joint Annual Action Plan (JAAP). The implementation of the JAAP's objective that calls for the strengthening of the Francophones' participation in planning health services through

community engagement led to significant accomplishment over the past year.

Working with both the Réseau and Francophone community stakeholders, the South East LHIN advances the integration of the Francophone perspective by supporting community engagement activities associated with the identified regional planning priorities. In 2013/14, projects such as AMH Redesign project, Health Links, and Palliative Care benefited from the Francophone community's participation to inform health services planning activities.

Healthcare professional networking activities were also collaboratively initiated in 2013/14 to foster informal and collaborative ties among French-speaking healthcare professionals and share experience while promoting organizational leadership in regards to the provision of health services in French.

The South East LHIN and the Réseau engaged in strategic discussions to better define the communication and community engagement approaches so greater outcomes could be achieved out of each event.

After the creation, in 2012, of the French Language Citizens' Advisory Committee the South East LHIN along with the Réseau offered multiple information sessions on the ongoing projects to enhance the Committee's knowledge of health care priorities. These sessions aim at enabling the Committee to provide guidance, feedback, and suggestions on the manner in which the development of French language health services could best serve francophone residents throughout the South East.

System Wide Quality Improvement

For change to influence and be adopted throughout the entire system, solutions have to rise from a common understanding of the issues, a shared vision of the outcomes for the system but more importantly for the patient. The South East LHIN engages leaders from all regional hospitals and CCAC on these matters.

The South East CCAC Hospital Executive Forum (SECHEF) engages administrative and clinical leadership of our Hospitals, CCAC, and the LHIN on decisions that will enable the regional system to meet provincial targets and to develop and implement quality improvement initiatives to ensure high quality integrated care is provided to patients across the region. Quality improvement initiatives also play an important role in maintaining the system sustainability.

Hospitals, CCAC directors and operational teams are frequently involved in several strategic planning discussions on various key topics related to hospital operations to identify improvement areas and efficiency possibilities. These strategic and operational discussions also occur with leaders from community care settings to further plan the implementation of cross-organizational initiatives. Tactical planning on current projects includes front-line staff and managers to help identify gaps in service, create suitable solutions, build relevant and comprehensive tools, and detect implementation barriers.

Through these relationships the South East LHIN conveys information and provides ongoing support by discussing and addressing administrative or performance concerns with leadership and operational teams. By working collaboratively with South East health care leaders and providers, the LHIN has been able to advance crucial integration initiatives such as: Resource Matching and Referral, Clinical Services Roadmap, Addictions and Mental Health Redesign, Palliative Care, and Diabetes programs. Each initiative leads to increased regional capacity through streamlined and integrated processes, optimized use of existing resources, and improved outcomes for patients across the South East region.

Health Care Professionals

The South East LHIN deploys constant efforts to engage and collaborate with primary care and health services professionals to better inform the LHIN on best practices to support high quality and integrated care across the care continuum.

Health Professional Advisory Committee

The Health Professional Advisory Committee (HPAC) is a multi-disciplinary committee helping the LHIN in carrying out its responsibilities by providing advice on how to better achieve patient-centered health care. The South East LHIN seeks the HPAC support and feedback regularly to enlighten current initiatives.

Over the last fiscal year the South East LHIN actively engaged and gathered feedback and advice from the HPAC on projects such as:

- Health Links
- AMH Redesign
- CSR
- Patient Flow
- Respite and Convalescent Care
- Physiotherapy
- ED CCAC

Primary Care

Engaging primary care physicians in the South East on processes is paramount to achieving improved linkages between primary care and the rest of the healthcare system. LHINs recognize that effective engagement is a strong enabler to creating an integrated healthcare system and a better experience for patients in Ontario. To support achievement of outcomes LHINs have used a variety of approaches to engage with primary care physicians.

The South East primary care Lead acts as a facilitator and initiator of many activities to inform, consult and collaborate with primary care providers and practitioners in support to the South East LHIN initiatives.

Over the last period, the South East LHIN held the 6th Primary Health Care Forum to inform more than 200 participants including HSPs from all sectors, patients and caregivers. The focus of the forum was on patient engagement as a way to improve the quality of care and health outcomes. Accredited by the Ontario College of Family Physicians and by the Canadian College of Health Leaders, the Forum allowed primary care providers and others to share information and gain insight on how to enhance

patient engagement at various points in of the healthcare system including design and provision of care.

Primary Health Care Council

In order to build and maintain strong relationships with primary care and cross-sector professionals, the South East LHIN primary care leadership convenes on a regular basis to work towards an integrated, patient-centered, high quality health care system. All stakeholder organizations share information and collaborate to develop strategies and to enhance local and regional healthcare initiatives such as:

- Health Links
- Health system leadership development
- Convalescent care beds
- Outpatient laboratory services
- Primary care issues related to ED utilization

Governance

Through the holding of monthly open board meetings and regular board to board discussions the South East LHIN board of Directors hopes to maintain a continuous contact with the general public, local communities as well as with health services providers and organizational leaders.

The South East LHIN Board of Directors is maintaining and building strong and collaborative partnerships with other boards to support the LHIN goal to build, improve, and sustain health services for the region and the communities within.

Collaborative Governance and Community Engagement Committee

The Collaborative Governance and Community Engagement Committee's main objective is to engage the regional community of Health Service Providers (HSPs), and additional provider agencies and organizations, in a way that encourages development and implementation of governance-based integration initiatives. By putting the emphasis on integration of patient pathways, strengthening communications, and building leadership within local communities, the committee hopes to achieve its vision of A Patient-Centered Health Care System that provides

seamless and integrated experience for patients and their families along the continuum of care.

Governance Excellence workshop

During the 2013 Governance Excellence Workshop the South East LHIN Board of Directors engaged members from the boards of healthcare organizations across the region with the focus on building collaboration as well as achieving the following main goals:

- To promote excellence in health service provider board governance;
- To facilitate mutual understanding among boards of agencies included in Health Links;
- To support the South East LHIN and local HSPs in establishing and achieving regional health care goals.

In fiscal 2013/14, over 100 participants attended the Workshop held in Kingston, leading to increased collaboration among partners and the communities which they serve.

This event allowed for the presentation of a common framework to support the concept of collaborative governance and the underlying principles of a one system of integrated care concept. The South East LHIN continues to promote the framework among provider agencies and will work on refining the tool in 2014/15.

The South East LHIN and two other organizations have adopted the framework presenting objectives and actions for each of the following good governance principles:

- Relationship Building
- Leadership/Stewardship
- Growth/Learning
- Empowerment/Accountability
- Communication/Transparency
- Service and Fairness
- Accomplishment and
- Measurement

PERFORMANCE INDICATOR REPORT

The MLPA sets out the obligations of the MOHLTC and the South East LHIN to fulfill its mandate to plan manage and fund local health care services. Developing and updating this accountability agreement is a key component of the relationship between the MOHLTC and the LHIN and helps us strengthen our local health care.

SOUTH EAST LHIN PERFORMANCE INDICATORS - May 12, 2014 Release 2013/14 ANNUAL REPORT

PI No.	Performance Indicator	LHIN 2013/14 Starting Point	LHIN 2013/14 Performance Target	Most Recent Quarter 2013/14 LHIN Performance	FY 2013/14 LHIN Annual Result
1: Access to healthcare services					
All of the facilities in the South East maintained Emergency Room (ER) Length of Stay (LOS) for admitted patients within target, except Kingston General Hospital (KGH). A continued focus on patient flow activities is still required at KGH - internally and with their system partners - where ER LOS is generally higher for admitted patients. The implementation of the Rapid Assessment Zone at KGH should also help reduce the length of stay in ER for Non-Admitted Minor Uncomplicated patients. While high percentages of patients across the South East achieve fast access to cancer surgery and cataract procedure, reduced Operating Room (OR) times and increasing demand for priority IV Cardiac By-Pass as affected performance. Additional investigation revealed that the metrics compiled to calculate this indicator were not consistent with the MOHLTC definition and actual performance measured against the 90 day access target is expected to be substantially better. The targets for hip and knee replacement procedures were also not achieved for this reporting period. The focus this fiscal year on Priority IV cases has highlighted an evident discrepancy across the South East LHIN in the assignment of priority (III or IV) to cases relative to the rest of the province. Until the prioritization of cases across the LHIN is standardized, it is unlikely that the LHIN will meet the 90% targets for hip and knee replacements.					
1	90th percentile ER length of stay for admitted patients	24.93	24.90	27.07	24.95
2	90th percentile ER length of stay for non-admitted complex (CTAS I-III) patients	6.78	6.80	6.87	6.78
3	90th percentile ER length of stay for non-admitted minor uncomplicated (CTAS IV-V) patients	4.05	4.00	4.33	4.23
4	Percent of priority IV cases completed within access target (84 days) for cancer surgery	94.00%	90.00%	95.09%	96.53%
5	Percent of priority IV cases completed within access target (90 days) for cardiac by-pass surgery	99.30%	90.00%	70.00%	84.00%
6	Percent of priority IV cases completed within access target (182 days) for cataract surgery	98.00%	90.00%	93.46%	96.31%
7	Percent of priority IV cases completed within access target (182 days) for hip replacement	93.00%	90.00%	34.78%	58.62%
8	Percent of priority IV cases completed within access target (182 days) for knee replacement	93.00%	90.00%	77.55%	86.90%
9	Percent of priority IV cases completed within access target (28 days) for MRI scans	69.00%	80.00%	80.89%	68.33%
10	Percent of priority IV cases completed within access target (28 days) for CT scans	93.00%	90.00%	93.21%	93.13%
2: Integration and coordination of care					
When it comes to patient getting fast access to CCAC in home care, the South East LHIN remains a high performer with substantially faster access than most LHINs and well below the provincial average of 42 days. By supporting the development and implementation of support services in the community the South East LHIN has persistently reduced the percentage of ALC days. Initiatives such as iCart, Seniors Friendly Hospital, Home first and Nurse Lead Outreach Teams represent ways to alleviate barriers to patient flow. Challenges remain with periods of reduced flow of ALC patients to Long Term Care Homes resulting in stress on the hospital system. Perversely, these periods result in a low percentage of ALC until such time as these patients are discharged from hospital and the metric spikes. An ALC indicator that is more responsive and actionable will be proposed for consideration to the Ministry.					
11	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	13.37%	12.90%	16.28%	13.16%
12	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	22.00	22.00	21.00	22.00
3: Quality and improved health outcomes					
The South East LHIN expects to see improved results for patients being readmitted to hospital from enhanced coordination happening through the Health Links and the implementation of the South East Health Integrated Information Portal (SHIIP). The additional investment to community AMH services has allowed for more crisis and transitional workers to be hired which is expected to help reduce repeat emergency visits for both Mental Health and Substance Abuse issues.					
13	Readmission within 30 Days for Selected CMGs**	17.70%	17.50%	17.31%	16.85%
14	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	18.50%	17.30%	20.17%	20.30%
15	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	21.80%	21.80%	22.64%	22.53%

*FY 2013/14 is based on most recent four quarters of data (Q4 2012/13 - Q3 2013/14) due to availability

**FY 2013/14 is based on most recent four quarters of data (Q3 2012/13 - Q2 2013/14) due to availability

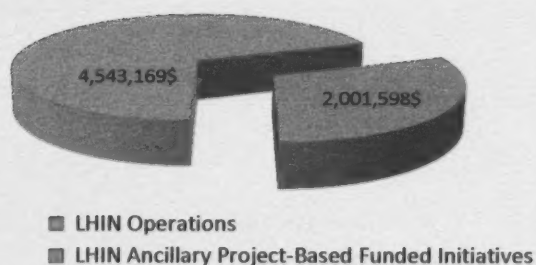
SOUTH EAST LHIN OPERATIONAL PERFORMANCE ANALYSIS

The South East LHIN total managed funding in 2013/14 was \$6.5M, representing an 11 per cent increase from prior the year. While LHIN Operations funding levels remained unchanged from the prior year, there was an overall increase in projects' allocation due primarily to funding for Diabetes and Chronic Disease Management initiatives; this funded initiative began in February 2013 which required only two months of funding in prior fiscal.

Ancillary Project-Based Funding

The LHIN received special funding for projects supporting the MOHLTC health system priorities as well as the LHIN's third Integrated Health Services Plan "Better Integration, Better Health Care." Figure 8 shows the Allocation of the total funding between LHIN operations and ancillary project-based initiatives.

Figure 8: Allocation of Total Managed Funding
Fiscal Year 2013/2014



Ancillary project-based funding is used to support human resources required to achieve the initiatives. These resources are co-located at the South East LHIN office facility. These projects included:

- Enabling Technologies
- Project Management Office
- Chronic Disease Management & Diabetes Strategy
- Emergency Room/Alternative Level of Care Strategy
- Emergency Department Initiative
- Aboriginal Community Engagement Initiative
- French Language Services Initiative
- Critical Care Initiative
- Primary Care Initiative
- Physiotherapy Initiative

Accreditation Canada

During 2013/2014, the South East LHIN has maintained its accreditation from Accreditation Canada – becoming the first LHIN in the province to do so.

2013/2014 AUDITED FINANCIAL STATEMENTS

An external audit was conducted by Deloitte LLP in April 2014. A copy of the auditor's report, along with audited financial statements & notes disclosures are provided in the following section of this document. The results of the audit for the 2013/2014 fiscal year were very positive, with no errors or mis-statements noted.

Financial statements of

**South East Local Health
Integration Network**

March 31, 2014

South East Local Health Integration Network

March 31, 2014

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Independent Auditor's Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the accompanying financial statements of the South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2014, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2014, and the results of its operations, change in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

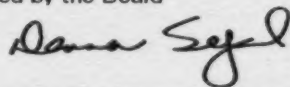
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 26, 2014

South East Local Health Integration Network

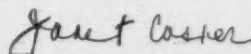
Statement of financial position as at March 31, 2014

	2014	2013
	\$	\$
Financial assets		
Cash	841 489	1 087 305
Accounts receivable (Note 3)	48 061	54 990
	889 550	1 142 295
Liabilities		
Accounts payable and accrued liabilities (Note 4)	613 718	596 707
Due to Ministry of Health and Long-Term Care (Note 5b)	68 929	318 212
Due to the LHIN Shared Services Office (Note 7)	4 640	9 792
Due to Champlain LHIN (Note 5c)	4 346	-
Deferred capital contributions (Note 8)	294 971	393 052
Obligations under capital lease (Note 16)	236 150	264 038
	1 222 754	1 581 801
Net debt	(333 204)	(439 506)
Commitments (Note 15)		
Non-financial assets		
Prepaid expenses	38 233	46 454
Tangible capital assets (Note 9)	294 971	393 052
	333 204	439 506
Accumulated surplus	-	-

Approved by the Board



Donna Segal - Board Chair



Janet Cosier - Finance and Audit Committee Chair

South East Local Health Integration Network

Statement of operations year ended March 31, 2014

	Budget (Note 10)	2014 Actual	2013 Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 11)	1 051 759 886	1 114 231 259	1 099 257 331
Operations of LHIN (Note 5)	4 543 169	4 524 204	4 534 906
Enabling Technologies (Note 6a)	-	580 000	580 000
Emergency Department (Note 6b)	-	75 000	75 000
Aboriginal Initiative (Note 6c)	15 000	15 000	15 000
ER/ALC Initiative (Note 6d)	-	100 000	100 000
French Language Services Initiative (Note 6e)	106 000	106 000	106 000
Critical Care Initiative (Note 6f)	-	75 000	75 000
Primary Care Initiative (Note 6g)	-	75 000	75 000
Chronic Disease Management (Note 6h)	-	948 254	329 119
Physiotherapy (Note 6i)	-	27 344	-
Amortization of deferred capital contributions (Note 8)	-	117 046	120 796
	1 056 424 055	1 120 874 107	1 105 268 152
Funding repayable to the MOHLTC (Note 5a)	-	(73 275)	(318 212)
	1 056 424 055	1 120 800 832	1 104 949 940
Expenses			
Transfer payments to HSPs (Note 11)	1 051 759 886	1 114 231 259	1 099 257 331
General and administrative (Note 12)	4 543 169	4 627 946	4 655 665
Enabling Technologies (Note 6a)	-	575 654	489 773
Emergency Department (Note 6b)	-	47 179	51 425
Aboriginal Initiative (Note 6c)	15 000	15 000	15 000
ER/ALC Initiative (Note 6d)	-	100 000	100 000
French Language Services Initiative (Note 6e)	106 000	106 000	96 835
Critical Care Initiative (Note 6f)	-	72 000	72 000
Primary Care Initiative (Note 6g)	-	74 667	75 000
Chronic Disease Management (Note 6h)	-	923 783	136 911
Physiotherapy (Note 6i)	-	27 344	-
	1 056 424 055	1 120 800 832	1 104 949 940
Annual surplus and accumulated surplus, end of year	-	-	-

South East Local Health Integration Network

Statement of change in net debt year ended March 31, 2014

	2014	2013
	\$	\$
Annual surplus	-	-
Acquisition of tangible capital assets	(18 965)	(8 263)
Amortization of tangible capital assets	117 046	120 796
Decrease (increase) in prepaid expenses, net	8 221	(18 109)
Decrease in net debt	106 302	94 424
Net debt, beginning of year	(439 506)	(533 930)
Net debt, end of year	(333 204)	(439 506)

South East Local Health Integration Network

Statement of cash flows year ended March 31, 2014

	2014	2013
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of tangible capital assets	117 046	120 796
Amortization of deferred capital contributions (Note 8)	(117 046)	(120 796)
Changes in non-cash operating items		
Decrease in accounts receivable	6 929	2 011
Decrease (increase) in prepaid expenses	8 221	(18 109)
Increase (decrease) in accounts payable and accrued liabilities	17 011	(525 035)
Decrease in due to MOHLTC	(249 283)	(29 532)
Increase in due to Champlain LHIN	4 346	-
(Decrease) increase in due to the LHIN Shared Services Office	(5 152)	9 792
	(217 928)	(560 873)
Capital transaction		
Acquisition of tangible capital assets	(18 965)	(8 263)
Financing transactions		
Increase in deferred capital contributions (Note 8)	18 965	8 263
Repayment of obligations under capital lease	(27 888)	(26 530)
	(8 923)	(18 267)
Net change in cash	(245 816)	(587 403)
Cash, beginning of year	1 087 305	1 674 708
Cash, end of year	841 489	1 087 305

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into a Performance Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas based on where residents primarily received their care (98% of all South East LHIN residents obtain care from local health service providers). The LHIN allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion.

The LHIN is home to over 500,000 people and has a geographic area which spans 19,473 square kilometers; the South East LHIN is the fourth largest geographic local integration network. The LHIN serves approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area. The LHIN encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("Performance Agreement"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2014.

The LHIN statements do not include any Ministry managed programs.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and losses in the book value of assets.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at cost. Cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Operations betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized, on a straight line basis, over their estimated useful lives as follow:

Office equipment	5 years
Computer equipment	3 years
Infrastructure/Web developments	3 years
Leasehold improvements	Life of lease

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Operations and within the related notes for both the prior and current year sufficiently disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

3. Accounts receivable

At March 31, 2014 the LHIN has accounts receivable of \$48,061 (2013 - \$54,990) which represents HST receivable for the last quarter of the fiscal year.

4. Accounts payable and accrued liabilities

At March 31, 2014 the LHIN has accounts payable and accrued liabilities of \$613,718 (2013 - \$596,707). This amount represents accounts payable (Trade) of \$218,334 (2013 - \$157,875), and accrued liabilities \$395,384 (2013 - \$438,832).

5. Funding repayable to the MOHLTC

In accordance with the Performance Agreement, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the accounting policy related to deferred capital contributions (Note 2) the LHIN has recognized as revenue ("funding received"), the amortization of deferred capital contributions of \$117,046 (2013 - \$120,796), and the 2014 deferred revenue from capital contributions of \$18,965 (2013 - \$8,263). This has resulted in an increase to the overall LHIN Operations revenue as shown in Note 5(a) below:

	2014	2013
	\$	\$
LHIN Operations base funding	4,543,169	4,543,169
Less: Deferred revenue from capital contributions	(18,965)	(8,263)
LHIN Operations Revenue (Statement of Operations)	4,524,204	4,534,906
Add: Deferred revenue from capital contributions	117,046	120,796
LHIN Operations Funding (Note 5a)	4,641,250	4,655,702

(a) The amount repayable to the MOHLTC is made up of the following components:

			2014	2013
	Funding received	Related expenses	Excess funding	Excess funding
	\$	\$	\$	\$
Transfer payments to HSPs	1,114,231,259	1,114,231,259	-	-
LHIN operations	4,641,250	4,627,946	13,304	37
Enabling technologies	-	-	-	90,227
Emergency department initiative	75,000	47,179	27,821	23,575
Aboriginal initiative	15,000	15,000	-	-
ER/ALC Initiative	100,000	100,000	-	-
French Language Services Initiative	106,000	106,000	-	9,165
Critical Care Initiative	75,000	72,000	3,000	3,000
Primary Care Initiative	75,000	74,667	333	-
Chronic Disease Management	948,254	923,783	24,471	192,208
Physiotherapy	27,344	27,344	-	-
Repayable directly to MOHLTC	1,120,294,107	1,120,225,178	68,929	318,212
Enabling technologies, repayable to MOHLTC through Champlain LHIN	580,000	575,654	4,346	-
	1,120,874,107	1,120,800,832	73,275	318,212

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

5. Funding repayable to the MOHLTC (continued)

(b) The amount due to the MOHLTC at March 31 is made up as follows:

	2014	2013
	\$	\$
Opening balance	318,212	317,651
Funding repaid during the year	(318,212)	(317,651)
One-time funding repayable to MOHLTC	55,625	318,175
LHIN Operations funding repayable to MOHLTC	13,304	37
Closing balance	68,929	318,212

(c) The amount due to the MOHLTC at March 31, is made up as follows:

	2014	2013
	\$	\$
One-time funding repayable to Champlain LHIN	4,346	-

6. Funding Initiatives

(a) *Enabling Technologies Initiative*

In fiscal 2014, the LHIN entered into an agreement with the South East, North East and North West LHINs (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Funding was provided to enable the cluster LHINs Project Management Offices to advance eHealth, information management and information technology initiatives as outlined in the ETI PMO Toolkit Business Case approved by the MOHLTC.

The LHIN's financial statement reflects its share of the MOHLTC funding for Enabling Technologies of \$580,000 in fiscal 2014. The total amount of funding for the Cluster in fiscal 2014 was \$2,320,000 and was received from the MOHLTC by the Champlain LHIN on behalf of the Cluster. The funding was split equitably amongst the South East, North East, North West and Champlain LHINs. The SE LHIN is required to book all surplus for this project to "Payable to Champlain LHIN"; the Lead LHIN (Champlain) is responsible for returning those funds to the MOHLTC on behalf of the cluster.

	2014	2013
	\$	\$
Expenses		
Salaries and benefits	463,754	302,157
Travel	17,435	21,908
Meeting expenses	550	5,270
Other	93,915	160,438
	575,654	489,773

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

6. Funding Initiatives (continued)

(b) Emergency Department Initiative

During fiscal 2014, the LHIN received funding in the amount of \$75,000 (2013 - \$75,000) from the MOHLTC. These funds were used toward resources to support the strategic Emergency Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan "Priority for Change". Unspent funds, amounting to \$27,821 (2013 - \$23,575) at year end, are repayable to the MOHLTC.

	2014	2013
	\$	\$
Expenses		
Consulting	45,600	49,500
Travel/Other	1,579	1,925
	47,179	51,425

(c) Aboriginal Initiative

During fiscal 2014, the LHIN received funding in the amount of \$15,000 (2013 - \$15,000) from the MOHLTC. These funds were used toward planning activities including assistance with the Metis Health Survey and engagement with the Aboriginal community including the newly formed Indigenous Council at the Napanee CHC in support of the Integrated Health Services Plan "Priority for Change".

	2014	2013
	\$	\$
Expense		
Other	15,000	15,000

(d) ER/ALC Initiative

During fiscal 2014, the LHIN received funding in the amount of \$100,000 (2013 - \$100,000) from the MOHLTC. These funds were used toward resources to support the ER/ALC Strategy.

	2014	2013
	\$	\$
Expenses		
Salaries and benefits	100,000	99,387
Travel	-	613
	100,000	100,000

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

6. Funding Initiatives (continued)

(e) French Language Services Initiative

During fiscal 2014, the LHIN received funding in the amount of \$106,000 (2013 - \$106,000) from the MOHLTC. These funds were used towards resources to support the French Language Services Strategy.

Actual expenditures incurred as part of the French Language Services Initiative activities were in excess of the \$106,000 funding provided by the MOHLTC. The total of actual expenses is \$111,880. The overage of \$5,880 has been funded through LHIN Operations base.

	Funded from LHIN operations	Direct fund	2014 Total	2013 Total
	\$	\$	\$	\$
Expenses				
Salaries and benefits	5,880	82,713	88,593	76,379
Travel	-	6,351	6,351	3,724
Meeting expenses	-	-	-	128
Other	-	16,936	16,936	16,604
	5,880	106,000	111,880	96,835

(f) Critical Care Initiative

During fiscal 2014, the LHIN received funding in the amount of \$75,000 (2013 - \$75,000) from the MOHLTC. These funds were used towards resources to support the Critical Care Strategy. Unspent funds, amounting to \$3,000 (2013 - \$3,000) at year end, are repayable to the MOHLTC.

	2014	2013
	\$	\$
Expenses		
Consulting	72,000	72,000

(g) Primary Care Initiative

During fiscal 2014, the LHIN received in-year funding in the amount of \$75,000 (2013 - \$75,000) from the MOHLTC. These funds were used toward resources for planning and engagement with Primary Health Care providers in support of the Integrated Health Services Plan "Priority for Change." Unspent funds, amounting to \$333 (2013 - \$Nil) at year end, were repayable to the MOHLTC.

	2014	2013
	\$	\$
Expenses		
Consulting	72,000	72,000
Travel	2,612	2,480
Meeting expenses	55	480
Other	-	40
	74,667	75,000

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

6. Funding Initiatives (continued)

(h) Chronic Disease Management

During fiscal 2014, the LHIN received funding in the amount of \$948,254 (2013 - \$329, 119) from the MOHLTC. These funds were used towards resources to support Chronic Disease Management and the Ontario Diabetes Strategy for Ontarians in support of the Integrated Health Services Plan. Unspent funds, amounting to \$24,471(2013 - \$192,208) at year end, are repayable to the MOHLTC.

	2014	2013
	\$	\$
Expenses		
Salaries and benefits	777,805	59,867
Travel	24,675	1,329
Other	121,303	75,715
	923,783	136,911

(i) Physiotherapy

During fiscal 2014, the LHIN received funding of \$27,344 (2013 - \$Nil) towards resources to support the Physiotherapy Initiative.

	2014	2013
	\$	\$
Expenses		
Salaries and benefits	27,344	-

7. Related party transactions

LHIN Shared Services Office (LSSO)

The LSSO is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Collaborative (LHINC)

LHINC was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- Fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- Their role as system manager;
- Where appropriate, the consistent implementation of provincial strategy and initiatives;
- The identification and dissemination of best practices; and
- LHINC is an LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the ministry of health and long-term care.

LHINC is a division of Toronto Central LHIN and as such is subject to the same policies, guidelines and directives as the Toronto Central LHIN.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

8. Deferred capital contributions

	2014	2013
	\$	\$
Balance, beginning of year	393,052	505,585
Capital contributions received during the year	18,965	8,263
Amortization for the year	(117,046)	(120,796)
Balance, end of year	294,971	393,052

9. Tangible capital assets

			2014	2013
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office equipment	408,007	344,270	63,737	135,512
Computer equipment	149,635	133,319	16,316	6,802
Leasehold improvements	358,197	143,279	214,918	250,738
	915,839	620,868	294,971	393,052

10. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the Statement of Operations reflect the initial budget at April 1, 2013. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of \$1,114,231,259 is made up of the following:

	\$
Initial HSP funding budget	1,051,759,886
Adjustment due to announcements made during the year	62,471,373
Total HSP funding budget	1,114,231,259

The total operating budget of \$4,543,169 is made up of the following:

	\$
Initial budget	4,543,169
Additional funding received during the year	-
Total budget	4,543,169

South East Local Health Integration Network

Notes to the financial statements

March 31, 2014

11. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of \$1,114,231,259 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2014	2013
	\$	\$
Operation of Hospitals	690,025,790	721,433,597
Grants to compensate for Municipal Taxation - Public Hospitals	190,725	190,725
Long-Term Care Homes	176,939,060	170,990,709
Community Care Access Centres	117,582,573	108,497,833
Community Support Services	31,604,448	30,132,287
Assisted Living Services in Supportive Housing	2,048,566	2,048,566
Community Health Centres	28,049,843	23,054,049
Community Mental Health Addictions Program	67,790,254	42,909,565
	1,114,231,259	1,099,257,331

12. General and administrative expenses

(a) The Statement of Operations presents expenses by function. The following classifies general and administrative expenses by object, as follows:

	2014	2013
	\$	\$
Program based		
Salaries	3,306,308	3,321,827
Consulting and LHIN-based projects	28,110	135,185
	3,334,418	3,457,012
Shared services	378,674	294,616
Collaborative	54,357	47,500
Other (Note 12b)	216,670	218,153
Occupancy	192,172	214,889
Office equipment and supplies	136,321	133,310
Board per diem	69,075	68,700
Public relations	67,053	49,412
Mail, courier and telecommunications	62,160	51,277
	4,510,900	4,534,869
Amortization	117,046	120,796
	4,627,946	4,655,665

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Notes to the financial statements

March 31, 2014

12. General and administrative expenses (continued)

(b) The breakdown of "Other" general and administrative expenses listed in the table above are:

	2014	2013
	\$	\$
Training and development	83,023	86,827
Travel	120,852	114,430
Recruitment	5,656	10,709
Insurance	6,883	6,634
Other miscellaneous	256	(447)
	216,670	218,153

(c) The total expenses related to governance is as follows, and are included in the expenses listed in Note 12(a) above:

	2014	2013
	\$	\$
Board chair per diems	26,075	31,500
All other per diems	43,000	37,200
Total per diems	69,075	68,700
Other administrative costs	57,095	42,559
Total governance expenditures	126,170	111,259
Overhead - salaries, benefits, accommodations and shared services	156,688	154,417
Total governance related costs	282,858	265,676

(d) The total occupancy and shared service costs are reduced from actual expenses in Note 12(a) above, due to partial cost sharing with ancillary funded projects for project staff that utilize office space and or shared services during the year.

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2014 was \$293,150 (2013 - \$274,129) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2013. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

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Notes to the financial statements

March 31, 2014

15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building lease as follows:

	\$
2015	224,064
2016	224,064
2017	224,064
2018	224,064
2019	224,064
Thereafter	429,456
	<u>1,549,776</u>

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2014, the LHIN had signed Performance Agreements with all Hospitals and Community Agencies for the next one to three years dependent upon the specific sector. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

16. Obligations under capital lease

The LHIN has a lease under the provision of capital lease of leasehold improvements. The cost of this lease is included in equipment and the related liabilities are included in long-term debt to reflect the effective acquisition and financing of these items. The lease on the building expires in February, 2021.

The present value of future minimum rentals is as follows:

	\$
2015	40 456
2016	40 456
2017	40 456
2018	40 456
2019	40 456
Thereafter	77 540
Future minimum lease payments	279 820
Less: amount representing interest	(43 670)
Present value of future minimum rentals	<u>236 150</u>

Principal payments required on this long-term debt for the next five years are as follows:

	\$
2015	29,314
2016	30,814
2017	32,390
2018	34,048
2019	35,790
Thereafter	73,794
	<u>236,150</u>





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